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General practice

Controversy in primary care

Does continuity in general practice really matter?

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Continuity is an official core value of general practice in the United Kingdom,¹ but there are at least two potentially conflicting definitions of it. Both definitions are powerfully expressed in a recent report from the BMA, entitled *Shaping Tomorrow*.²

For general practitioners, continuity of care has traditionally meant that a patient visits the same doctor.³⁻⁴ What matters is personal continuity, in which an ongoing doctor-patient relationship ensures that care takes account of the patient's personal and social context. By contrast, recent statements from the NHS Executive emphasise the importance of consistency and coordination of care.⁵ From this perspective, continuity can be enhanced by appropriate organisation, guidelines, and electronic medical records, irrespective of which doctor is seen.

Does seeing the same doctor matter?

Most research about the impact of continuity of care has been conducted in antenatal care or in specialist care settings in the United States.⁶⁻¹⁰ Generalising these results to general practice in the United Kingdom is possible but problematic. Research shows that a patient's enablement and satisfaction with a consultation is strongly associated with visiting the same doctor.¹¹⁻¹³ Patient satisfaction is also higher in practices that are small, non-training, or have personal lists.¹³⁻¹⁴ Smaller studies in the United Kingdom have had more inconsistent results, some showing no effect on quality of care and others showing that when doctors know patients well, compliance and the accuracy of diagnosis are increased.¹⁵⁻¹⁷



Dr Finlay's Casebook: the traditional view of personal continuity

Summary points

Continuity, in the sense of visiting the same doctor, is a core value of general practice in the United Kingdom

It is increasingly presented as "old fashioned" and in opposition to the development and modernisation of primary care

The implicit choice between personal continuity and modern care is false; what evidence there is suggests that patients prefer services providing personal continuity, and this may also reduce the use of investigations and admissions to hospital

If general practitioners really believe that it matters that a patient visits the same doctor, they need to ensure that this is taken into account in the development of primary care

Overall, there is a reasonably strong and consistent association between continuity and patient and doctor satisfaction. The evidence of associations with better medical outcomes such as compliance, uptake of preventive care, and use of resources, including admission to hospital, is less strong and often based on research in other countries and settings. It seems likely that there will be patients and problems where personal continuity really matters and others where personal continuity is irrelevant or even harmful, but this has not been researched in detail.

Personal continuity and development of general practice

All major NHS reorganisations intended to promote the development of general practice seem likely to have reduced personal continuity. Examples include the growth of group practice, the decline of personal lists, sharing of out of hours care, and the provision of drop-in clinics. Some of these changes have undoubtedly brought benefits for patients as well as for doctors.

So is there really a conflict between the core value of personal continuity and the development of modern general practice? There are competing images

invoked. Traditional personal continuity is often dismissed as irrelevant and outdated, to be consigned to history in the name of progress. The inevitable image is that of Dr Findlay, loved by his patients but with gently decaying premises, skills, knowledge, and effectiveness.² By contrast, the image of progress and development is the modern group practice, similar to a small hospital with its large multidisciplinary team, specialist clinics, and guidelines.² That patients are less satisfied with the care provided by such a practice often seems irrelevant to its proponents.^{2 13 14}

These images seem not to allow compromise. The real organisational choice, however, is not necessarily between singlehanded practice and the "polyclinic" or between the personal and the technical—it is more often between small teams and large teams. Is it really necessary to lose the personal advantages of a small team to gain the organisational advantages of a large one?

What is to be done?

Organisational change offers opportunities as well as threats. In the past, the development of general practice has meant that clinical units have become larger and personal continuity has declined. Little alternative exists when the practice is the basic clinical and administrative unit. Primary care groups and local healthcare cooperatives may also promote larger clinical units in the name of efficiency, cost, and clinical governance.¹⁸ They also offer, however, the opportunity to separate administrative and clinical functions that work best on different scales.

Out of hours cooperatives have probably made it easier to sustain small practices by removing the grind of on-call rotas. Similarly, primary care groups may offer practices the advantages of administrative size without requiring that clinical units get bigger. The ideal clinical unit may be two to four doctors working in a team with nurses, health visitors, and other professionals.¹⁴ Such clinical units could share administrative, computing, prescribing, audit, and educational support with each other within primary care groups but would offer a more personal and individual service. The evidence is that patients prefer this kind of organisation and would probably have better medical outcomes from it.

If general practitioners are serious about personal continuity then they need to ensure that organisational change promotes it. In an increasingly evidence based

world, research into exactly when and for whom personal continuity really matters is needed to support the development of services that balance the differing perspectives of patients, doctors, and policymakers. If general practitioners are not serious enough about personal continuity to organise themselves and to provide it, then perhaps we should stop pretending that it matters and get on with creating the brave new world of polyclinics, walk in centres, and daytime cooperatives.

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Commentary: A patient's perspective of continuity

Sally Brampton

From a patient's perspective, I cannot emphasise too strongly the importance of personal continuity. I attend a large practice, which has five general practitioners and a high turnover of doctors. Recently, I had reason to question the notion of personal continuity.

Briefly, in late 1988 I began to have debilitating joint and muscle pains. I felt tired, depressed, bloated (I had put on more than a stone in weight that I could not shift), and constantly cold. I was so cold that I frequently sat in hot baths for up to an hour to increase my body temperature. I decided to see my doctor. As

the waiting time for an appointment with my own doctor was about a week, I decided I would visit the doctor with the earliest appointment. A blood test was conducted. I had a high white cell count, and it was assumed that I had an infection. Antibiotics were prescribed. At the time it was mentioned that my thyroid was marginally underactive and that it should be checked after six months.

The antibiotics had no effect. The symptoms continued, including the joint and muscular pains. At times the pains were so severe that I took painkillers

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every four hours. I spent hundreds of pounds on osteopath fees for a stiff neck and back. Three months later I went back to the surgery.

This time I saw a different doctor. I explained all my symptoms again, which took up to 10 minutes. I am always conscious of the workload of doctors, the time allowed for each appointment, and that if a patient is with a doctor for too long the appointment schedule is affected. This knowledge makes me hurry through an explanation of my symptoms. All in all, I saw four different doctors; until I ended up with the one who diagnosed my condition (underactive thyroid) and prescribed thyroxine. I have since felt completely well, but I regret the time it took to be diagnosed. I am now adamant that I will see only the doctor who diagnosed my condition and am prepared to wait, within reason, to ensure that I do.

Since childhood—I am now 44—I have had recurrent bouts of tonsillitis. I know the symptoms and the treatment well. My temperature increases to 104°C, my throat becomes covered in ulcers, and I need antibiotics. If treated, I am well within three days. If left untreated, it may take me up to two weeks to recover. A doctor familiar with my character and medical history would know this. Yet I have lost count of the times I have been told that throat infections are caused by

viruses, that viral infections are untreatable by antibiotics, and the dangers of antibiotics, and I have had to argue for a prescription.

The problem with lack of continuity in general practice is that the patient's character is not taken into account. Is he or she a malingerer or a whiner? Is he or she perhaps the person best qualified to understand and diagnose his or her own illness? What seems straightforward on paper may be less so in reality, and a busy doctor has little time to read a patient's notes comprehensively. This inevitably increases the consultation time and puts strain on the practice. It is also likely to make patients irritable and to affect their relationship with their doctors, making them more guarded than necessary.

What seems to work best—from an entirely subjective point of view—is a polyclinic, with its back up of specialist options, together with the opportunity to see the same doctor. If patients are offered no choice about this, they are likely to end up frustrated and resentful and feeling like just a number in a large machine. It is deflating to find a doctor distractedly flicking through your notes to try and gain a sense of your medical history. It is equally frustrating to have to answer the same questions asked just a week earlier, as the doctor tries to come to terms with your condition and character.

Rapid virological surveillance of community influenza infection in general practice

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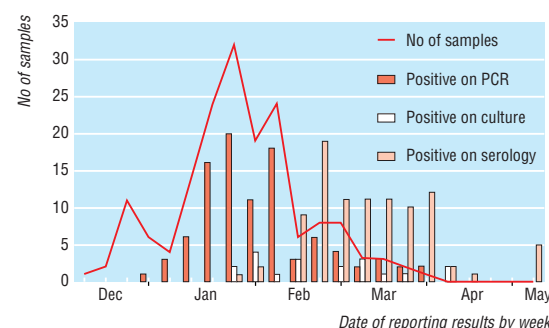
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The annual outbreak of influenza in Scotland is monitored by sentinel general practices, which report influenza-like illness. We piloted real time virological surveillance to investigate whether polymerase chain reaction (PCR)^{1,2} is useful for monitoring an outbreak while it is evolving; to compare PCR with two standard techniques—culture and serology; and to compare two media for submitting samples.

Methods and results

Six practices took part. Influenza-like illness was defined by using standard criteria. Combined nose and throat swabs were submitted in both lysis buffer³ and viral transport medium. Two serum samples were taken a minimum of three weeks apart. All samples were posted to the laboratory. Influenza A and B reverse transcription PCR was performed on both media.³ Primary rhesus monkey kidney cells (Bio-whittaker, Wokingham) were used to isolate virus. Influenza A and B antibodies were measured using the complement fixation test.

Patients were aged 17 to 72 years (mean 50.5 years), comprising 104 women and 64 men. Samples were taken 1-21 (mean 5.3) days after onset of illness, although 84% of samples were taken within seven days of onset.



Date of arrival of samples (line graph) at the laboratory and dates of reporting results for polymerase chain reaction, virus culture, and serology (bar charts)

PCR results were available within 36 hours of sample arrival, culture took at least a week, and serology took a minimum of three weeks in this study (figure). Overall, 112 (67%) patients had influenza infection that was confirmed by the laboratory. Of 168 samples, 97 were positive for PCR (57% overall): 84 for influenza A and 13 for influenza B. Nineteen of these also had positive results by culture. Of 153 patients tested serologically, 94 (61%) showed a rising or high (≥ 128) titre. Fifteen patients with positive serology had negative results with PCR;